Your Anthem Benefits

Anthem
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STATE OF INDIANA
Blue Preferred® Primary (HMO)
Summary of Benefits, Effective January 1, 2002

COVERED BENEFITS	PCP-REFER (MEMBER'S RESPONSIBILITY)
Out-of-Pocket Maximum (Single/Family)	$1,000/$2,000
Office Visit • Including Allergy – testing and treatment – serum and injections[1]	$0 Per Visit
Preventive Care	$0 Per Visit. Included with no age or dollar limits; no Self-refer benefits apply*. Preventive care includes: medical history, mammograms[1], pelvic exams and Pap tests, immunizations[1], routine and annual diabetic eye exams and hearing exams.
Maternity Services	Covered in full
Inpatient Services	Covered in full Per Admission
Outpatient Facility Services	Covered in full
Professional/Ancillary/Home Care (Inpatient/Outpatient)	Covered in full
Emergency and Urgent Care:	
Emergency Care in ER Room *(covers all services, waived if admitted)*	$10 per visit
Urgent Care Facility	$10 per visit
Hospice/Ambulance	Covered in full
Medical Supplies, Equipment and Appliances	Covered in full
Outpatient Therapy Visit Limits **Physical/Occupational** **Spinal Manipulation** **Speech**	No limits
Mental Health[2]	Covered in full. Subject to same copays and maximums.
Substance Abuse[2] (Substance abuse rehabilitation programs are limited to two per lifetime.)	
Inpatient: 20 PCP-refer days	Copayment based on place of service
Outpatient: 30 PCP-refer visits	Copayment same as office visit
Lifetime Maximum	$5 million (Excluding human organ and tissue transplants)
Human Organ and Tissue Transplants[3]	Covered in full PCP-refer
Prescription Drug Options:	**Network**
Network Retail Pharmacies: (30-day supply)	$5 Formulary generic and generic birth control/$10 Formulary brand $15 Non-formulary generic/$20 Non-formulary brand
Anthem Rx Direct Mail Service: (60-day supply)	$10 Formulary generic and generic birth control/$20 Formulary brand $20 Non-formulary generic/$30 Non-formulary brand

**Self-refer services are covered only with authorization by the Plan, except in medical emergencies.*

Notes:

- *Dependent age: to the end of the calendar year of age 19 age 23 if dependent qualifies as a federal tax exemption.*
- *Certain diabetic and asthmatic supplies are covered in full at network pharmacies.*

[3] *Human organ and tissue transplants (except kidney and cornea) are covered in full PCP-Refer. Subject to a separate $1 million lifetime maximum. Kidney and cornea are covered same as any other illness and subject to the medical lifetime maximum.*

This benefit description is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

EXCLUSIONS:

The following section indicates items which are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary.

We do not provide benefits for services, supplies or charges:

- For care not received from your PCP (Primary Care Physician) or performed as an authorized Referral Service; except for Emergency Care, Urgent Care, OB/GYN services and specified eye exams.
- Which we determine are not Medically Necessary.
- Received from an individual or entity that is not a Provider, as defined in this Certificate.
- For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For illness or injury that occurs as a result of any act of war, declared or undeclared.
- For a condition resulting from a riot, civil disobedience, nuclear explosion, or nuclear accident.
- For any Pre-Existing Condition for the time period specified in the Schedule of Benefits, subject to the Portability provision of this Certificate.
- For court ordered testing or care [unless Medically Necessary and authorized by your PCP (Primary Care Physician).
- For which you have no legal obligation to pay in the absence of this or like coverage.
- Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
- Received from a member of your immediate family, including your spouse, child, brother, sister, or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For mileage costs or other travel expenses, except as authorized by Us.
- For which benefits are payable under Medicare Part A and/or Medicare Part B or would have been payable if a Member had applied for Part A and/or Part B, except, as specified elsewhere in this Certificate, or as otherwise prohibited by Federal law, as addressed in the section titled Medicare in General Provisions.
- Charges in excess of Reasonable Charges.
- Incurred prior to your Effective Date.
- Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.

EXCLUSIONS (continued):

- For cosmetic treatment intended primarily to improve appearance but not to restore body function or correct deformity from disease, trauma, birth or growth defects or prior therapeutic processes.
- Services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable.
- For Custodial Care, domiciliary or convalescent care.
- For foot care only to improve comfort or appearance including, but not limited to care for flat feet, subluxations, corns, bunions (except capsular and bone surgery), calluses, and toenails.
- For dental treatment except as specified elsewhere in this Certificate.
- Related to weight loss or treatment of obesity, except for surgical treatment of morbid obesity.
- For sex transformation surgery and related services, or the reversal thereof.
- For marital counseling.
- For eyeglasses or contact lenses. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.
- For hearing aids or examinations for prescribing or fitting them.
- For services or supplies primarily for educational, vocational, or training purposes, except as otherwise provided for herein.
- For reversal of sterilization.
- [[For artificial insemination; fertilization (such as in vitro or GIFT) or procedures and testing related to fertilization; [infertility drugs and related services following the diagnosis of infertility.]]
- For or related to developmental delays, learning disabilities, hyperkinetic syndromes, or mental retardation (except for Prescription Drugs).
- For personal hygiene and convenience items.
- For care received in an emergency room which is not Emergency Care, except as specified in this Certificate.
- Related to radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
- Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above remain in place. This Exclusion includes services for implantation, removal and complications.
- For expenses incurred at a health spa or similar facility.
- For self-help training and other forms of non-medical self care, except as otherwise provided for herein.
- For examinations relating to research screenings.
- For stand-by charges of a Physician.
- Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
- For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility.
- For private duty nursing services except when provided through Home Care Services benefit.
- For treatment of intentionally self-inflicted injuries, suicide, or attempted suicide, whether sane or insane.
- Drugs in quantities which exceed the limits established by the Plan.
- Services and supplies related to sex transformation or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This Exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs**,** and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.

EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION

Any drug, device, diagnostic, product, equipment, procedure, treatment, supply ("Service") or charges which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply are not covered by the Plan. Details on the process and criteria the Plan uses to determine if a Service is Experimental/Investigative are outlined below.

If you disagree with our denial of a Service as Experimental/Investigative, you have the right to file a Grievance with Us. Please refer the **Member Grievances** section of this Certificate for more information.

Process to Determine an Experimental/Investigative Service

The Plan's process to determine whether a Service is Experimental/Investigative generally includes medical and technical research of the Service, committee review and decision, and final approval by the Plan's Chief Medical Officer.

First, the Plan's Medical Policy staff reviews a Service based on the criteria listed in the provision below. Information on the Service is gathered and consolidated by the Plan's Medical Policy staff into a formal evaluation that includes background information, a summary of research findings, and a draft of the Plan's formal policy.

Next, the draft of the policy and accompanying literature on the Service is distributed to the Plan's Medical Policy Committee for review and discussion. The committee, which generally meets four times a year, is comprised of a panel of Plan Physicians, a majority of which are actively practicing Network Physicians representing various medical specialties. The committee considers at a minimum the applicable scientific literature and information as required by regulatory entities. The committee may also request input from one or more physician consultants from a panel of consultants representing a wide range of the subspecialties of medicine.

After reviewing all information related to the Service, the committee recommends a final policy. The policy is forwarded to the Plan's Medical Policy Committee Chairman and Chief Medical Officer for approval.

The Plan's policy on a Service is reviewed as appropriate, generally every three years or less, by the Plan's Medical Policy staff and Medical Policy Committee, with approval of the Plan's Chief Medical Officer and Medical Policy Committee Chairman.

The Plan also maintains a process for determining when existing policy on a Service requires additional review and revision and alerts the Plan's Medical Policy Committee of the need to revise the existing policy or create a new policy. This may occur as a result of changes in peer-reviewed literature, clinical trials, regulatory status, or other medical information, which could alter or change the Plan's position on a current policy or intervention. An interim policy for approval of changes may be used on a limited basis by the Plan to make policy change between regularly scheduled meetings of the Medical Policy Committee.

Criteria to Determine an Experimental/Investigative Service

The criteria the Plan or Plan's designee apply when making the determination of whether a Service is Experimental/Investigative when it is rendered for the evaluation or treatment of a disease, injury, illness or condition is outlined below. The criteria must apply to the Service at the time the member receives or will receive the Service, and must apply to the medical use for which benefits are sought. The Service will be deemed Experimental/Investigative if the Service:

- cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA"), or other licensing or regulatory agency, and such final approval has not been granted; or

- is the subject of a current new drug or device application on file with the FDA; or

- is provided as part of a Phase I or Phase II clinical trial, is provided as the experimental or research arm of a Phase III clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Service; or

- is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy among its objectives; or

- is subject to the approval or review of an Institutional Review Board ("IRB") or other body that approves or reviews research concerning the safety, toxicity, or efficacy of services; or

- is provided pursuant to informed consent documents that describe the Service as Experimental/Investigative, or in other terms that indicate that the Service is being evaluated for its safety, toxicity, or efficacy.

Any Service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative if the Plan or Plan's designee determine that the Service meets any of the four criteria below:

- The scientific evidence does not permit conclusions concerning the effect of the Service on health outcomes; or

- The Service does not improve net health outcome by producing beneficial effects that outweigh any harmful effects; or

- The Service has not been shown to be as beneficial as any of the established alternative services with evidence demonstrating that the Service improves net health outcome as much as, or more than, established alternatives; or

- The Service has not been shown to improve net health outcomes under the usual conditions of medical practice outside clinical investigatory settings.

Documents relied upon by the Plan or Plan's designee to determine whether Services are Experimental/Investigative are based on the criteria in the sections above may, at the Plan's or Plan designee's discretion, include one or more items from the following list which is not all inclusive:

- the Member's medical records;

- the written protocol(s) or other document(s) pursuant to which the Service has been or will be provided;

- the published, authoritative, peer-reviewed medical or scientific literature regarding the Service as it applies to the Member's condition;

- any consent document(s) the Member or Member's representative have executed or will be asked to execute to receive the Service;

- the relevant documents of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided;

- any records, regulations, applications or other documents or actions issued by, filed with, or received by the FDA, the Office of Technology Assessment, or other federal or state agencies with similar functions, that the Plan or Plan's designee has in its possession at the time of the review; or

- opinions and evaluations by national medical associations or committees, consensus panels, or other technology evaluation bodies, such as the Blue Cross & Blue Shield Association's Technology Evaluation Center.

Services provided solely or primarily to support the administration of an Experimental/Investigative Service, or those provided to treat anticipated or unanticipated results of an Experimental/Investigative Service, will also be excluded from coverage. Services that are part of the same plan of evaluation or treatment as an Experimental/Investigative Service, but which, in the opinion of the Plan or Plan's designee, would, in the absence of the Experimental/Investigative Service be otherwise Medically Necessary, may be considered eligible for coverage, subject to all benefit requirements, limitations, and exclusions.

The Plan or its designee has the sole authority and discretion to determine all questions pertaining to whether a Service is Experimental/Investigative under this Certificate.